

Name: _____

Individualized Plan for Employment (IPE) - Job Goal

☐ Original ☐ Amended ☐ EW Plan

Job Goal: State the job you want to have at the end of your plan.

Comments/Responsibilities: _____

I expect to be working by: _____

Weekly Work Hours: How many hours do you expect to work each week?

☐ 14 or less

☐ 15 to 19

☐ 20 to 31

☐ 32 or more

Supported Employment

☐ Individual Placement

☐ Crew/Enclave Placement

☐ Transitional Placement

Continuing Help: Check each type of continuing help you will need to do well on your job.

Meet with me:

☐ Where I work at least 2 times a month to find out how I am doing on the job and what help I need.

OR

☐ Away from where I work at least 2 times a month to find out how I am doing on the job and what help I need.

☐ Talking to my boss and co-workers where I work about how to help me do well on my job.

☐ Training me where I work in the skills I need to do well on my job.

☐ Training me where I work in getting along with people.

☐ Get continuing help to do well on my job.

☐ Other help I will need to do well on my job (Describe) _____

Provider: Check who will give you or pay for the continuing help you need. (At least one box must be checked.)

☐ DD Service Coordination

☐ Coworker

☐ Community Mental Health Program

☐ Employer

☐ DD Service Provider

☐ Family Member _____

☐ Mental Health Clubhouse

☐ Other _____

☐ Advocacy/Support Group _____

Agreement and Approval: My plan will take effect when VR approves it. I agree that the job goal is in line with my strengths, priorities, concerns, abilities, capabilities, career interests, resources, and informed choices. I have been given a copy of the IPE Terms. I agree with them. I agree with the job goal, services, payment sources, and timelines described.

If I receive SSDI or SSI benefits based on my disability, I understand that by signing this Individualized Plan for Employment Job Goal, the Social Security Administration will consider me as "using my Ticket". While my Ticket is considered to be "in use" no continuing disability reviews (CDR) will be initiated as long as I make timely progress toward my goal.

Your Signature Date

Vocational Rehabilitation Contact

Parent, Guardian, or Representative Date

Vocational Rehabilitation Approval Date